Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
BSWH EQA Plan: Baylor Scott & White Health

Coverage Period: 01/01/2019 – 12/31/2019
Coverage for: EE and EF | **Plan Type:** EPO

⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. NOTE: Information about the cost of this **plan** (called the **premium**) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit bswh.swhp.org, or call 1-844-843-3229. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at cciio.cms.gov or call 1-844-843-3229 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $500 Employee Only (EE) / $1,000 Employee & Family (EF); Out-of-network: not covered; does not apply to preventive care	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. There is an embedded deductible for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children).
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you have not yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You do not have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	In-network: $4,000 Employee Only (EE) / $8,000 Employee & Family (EF); Out-of-network: not covered	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There is an embedded out-of-pocket limit for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children). Deductible included in out-of-pocket max.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bswh.swhp.org or call 1-844-843-3229 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

> ⚠️ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	$50 copay per visit; deductible does not apply	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $75 copay per visit; Labs: 30% coinsurance; deductible does not apply	Not covered	For prior authorization requirements see bswh.swhp.org/tools-and-resources.
	Imaging (CT/PET scans, MRIs)	$100 copay per visit for PET, CT, CAT, etc. $150 copay per visit for MRI		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bswh.swhp.org/pharmacy-information.	Preferred generic drugs	BSWH Pharmacy: $3 copay per 30-day supply / retail; $6 copay per 90-day supply / maintenance; deductible does not apply Contracted Pharmacy: $5 copay per 30-day supply / retail	Not covered	Copays are per 30-day supply. Two copays apply for a 90-day supply if a maintenance drug is obtained through a Baylor Scott & White pharmacy OR when using the mail order prescription service. Specific preventative medications will be covered with no cost to the member.
	Preferred brand drugs	BSWH Pharmacy: $35 copay per 30-day supply / retail $70 copay per 90-day supply / maintenance; deductible does not apply Contracted Pharmacy: $50 copay per 30-day supply / retail	Not covered	
	Non-preferred generic drugs and non-preferred brand drugs	BSWH Pharmacy: lesser of $50 or 50%	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
		coinsurance (retail); lesser of $100 or 50% coinsurance (maintenance); deductible does not apply Contracted Pharmacy: lesser of $75 or 50% coinsurance (retail)		
	Specialty drugs	BSWH Pharmacy: 20% with $200 maximum copay; deductible does not apply Contracted Pharmacy: not covered	Not covered	Available through Baylor Scott & White pharmacy only. Some drugs may require prior authorization. 30-day supply only.
If you have outpatient surgery If you need immediate medical attention	Facility fee (e.g., ambulatory surgery center)	$150 copay per visit; deductible does not apply	Not covered	None
	Physician/surgeon fees	0% after applicable copay	Not covered	
	Emergency room care	$250 copay per visit; deductible does not apply	$250 copay per visit; deductible does not apply	Copayment waived if admitted.
	Emergency medical transportation	$250 copay per visit; deductible does not apply	$250 copay per visit; deductible does not apply	Emergency transportation includes ground and air ambulance.
	Urgent care	$75 copay per visit; deductible does not apply	$75 copay per visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay per day (maximum of 5 days), then 0% coinsurance	Not covered	For prior authorization requirements see bswh.swhp.org/tools-and-resources.
	Physician/surgeon fees	0% after applicable copay	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay per visit; deductible does not apply	Not covered	None
	Inpatient services	$150 copay per day (maximum of 5 days), then 0% coinsurance	Not covered	None
If you are pregnant	Office visits	$30 copay per visit (PCP visit); $50 copay per visit (Specialist visit); deductible does not apply	Not covered	Cost sharing does not apply for preventive services. No charge for prenatal visits; postnatal visits are covered at the PCP/specialist copay. Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% after applicable copay	Not covered	
	Childbirth/delivery facility services	$150 copay per day (maximum of 5 days), then 0% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	10% after deductible	Not covered	120 visits per calendar year.
	Rehabilitation services	$50 copay per visit; deductible does not apply	Not covered	Combined occupational/physical therapy 60 visits max per calendar year, speech therapy 60 visits max per calendar year.
	Habilitation services	$50 copay per visit; deductible does not apply	Not covered	Combined occupational/physical therapy 60 visits max per calendar year, speech therapy 60 visits max per calendar year.
	Skilled nursing care	10% after deductible	Not covered	120 day max per calendar year
	Durable medical equipment	10% after deductible	Not covered	None
	Hospice services	10% after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Non-emergency care when traveling outside U.S.	• Routine foot care
• Dental care (Adult)	• Routine eye care (Adult)	• Weight loss programs
• Long-term care		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Acupuncture (20 visit limit per calendar year)	• Hearing aids (1 device every 36 months)
• Bariatric surgery	• Infertility treatment (Limited to $7,500 medical and $7,500 pharmacy lifetime max)
• Chiropractic care (20 visit limit per calendar year)	• Private-duty nursing (120 visit limit per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Optum, adminservices.optumhealthfinancial.com, or call 866-301-6681; Department of Labor Employee Benefits Security Administration, visit dol.gov/ebsa/healthreform , or call1-866-444-EBSA (3272). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Scott and White Health Plan, visit bswh.swhp.org/ , or call 1-844-843-3229; Department of Labor Employee Benefits Security Administration, visit dol.gov/ebsa/healthreform , or call 1-866-444-EBSA (3272).

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-843-3229.

––––––––––––––––––––––––––*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*–––––––––––––––––––––

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$500	■ The plan's overall deductible	$500	■ The plan's overall deductible	$500
■ Specialist copayment	$50	■ Specialist copayment	$50	■ Specialist copayment	$50
■ Hospital (facility) copay	$150	■ Hospital (facility) copay	$150	■ Hospital (facility) copay	$150
■ Other coinsurance	10%	■ Other coinsurance	10%	■ Other coinsurance	10%

This EXAMPLE event includes services like:
Sample Care Costs
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

This EXAMPLE event includes services like:
Sample Care Costs
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

This EXAMPLE event includes services like:
Sample Care Costs
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$12,800

Total Example Cost	$7,500

Total Example Cost	$1,900

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,300**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,660**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,360**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

Scott&White
HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Scott and White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex Scott and White Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Scott and White Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print and accessible electronic formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Scott and White Health Plan (SWHP) Compliance Officer at 1-254-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org.

If you believe that Scott and White Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

SWHP Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the SWHP Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Non-Discrimination Ntc_06/2018_English

Language Assistance

Scott&White
HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-321-7947 (TTY: 711).

Chinese:
注意:如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-800-321-7947(TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
هاتف الصم والبكم: 711 .ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-3141-334-866 (رقم

Urdu:
کال ۔ ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو ،ہیں بولتے اردو آپ اگر :خبردار 1-800-321-7947 (TTY: 711) .کریں

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa
1-800-321-7947 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-800-321-7947 (TTY: 711) पर कॉल करें।

Persian:
شما برای رایگان بصورت زبانی تسهیلات ،کنید می گفتگو فارسی زبان به اگر :توجه .بگیرید تماس 1-800-321-7947 (TTY: 711) با .باشد می فراهم

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 711).

Japanese:
注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-321-7947 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ
1-800-321-7947 (TTY: 711).